§ 9.75. Assurance of access to care.

(a) A health maintenance organization shall have and maintain adequate arrangements, such as written contracts, to provide the health service contracted for by its subscribers.

(b) A health maintenance organization shall have available sufficient personnel to meet the standards set forth in this chapter and its contractual obligations.

(c) A health maintenance organization shall make available to each subscriber a primary care physician to supervise and coordinate the health care of the subscriber.

(1) All referrals for specialty care, except in emergency situations, shall be approved by the subscriber's primary care physician.

(2) A subscriber who is dissatisfied with his primary care physician shall be allowed to select another; however, the health maintenance organization may impose a reasonable waiting period to accomplish this transfer.

(d) A health maintenance organization shall provide all covered basic health services which require the services of a specialist.

(1) In those specialties which are generally available and frequently utilized in the geographic area served by the health maintenance organization, services of qualified specialty practitioners shall be provided through effective arrangements between the health maintenance organization and the practitioner, assuring subscriber access to medically necessary specialty care. Letters signed by practitioners indicating their intent to participate in the health maintenance organization are an example of such arrangements.

(2) Medically necessary specialty services other than those described in paragraph (1) shall be provided by participating or nonparticipating specialists.

(3) A health maintenance organization shall provide for coordination nad continuity of care for subscribers referred to nonparticipating specialists.

(4) When a subscriber is referred by a health maintenance organization or by a health maintenance organization physician to a nonparticipating specialist, the subscriber shall incur no financial liability above that which he would have incurred had he been referred to a participating specialist.

(e) A health maintenance organization shall have written procedures governing the availability of frequently utilized services contracted for by subscribers, including at least the following:

(1) Well patient examinations and immunizations.

(2) Emergency telephone consultation on a 24-hour per day, 7-day per week basis.

(3) Treatment of acute emergencies.

(4) Treatment of acute minor illness.

(5) Treatment of chronic illnesses.

(f) A health maintenance organization shall have a written procedure for payment of emergency health services provided outside of its service area.

§ 9.76. Professional staffing of health maintenance organizations.

(a) *Professional staff standards.*

(1) A health maintenance organization shall have at least the equivalent of one full-time primary care physician per 1600 members.

(2) To qualify as a primary care physician, a physician must meet one of the following conditions:

(i) He performs the functions of a primary care physician as defined in § 9.2 (relating to definitions) at least 50% of the time in which he engages in the practice of medicine.

(ii) He has limited his practice of medicine for at least 2 years prior to association with the health maintenance organization to general practice, internal medicine, pediatrics, or family medicine.

(3) As an overall ratio for all physicians serving health maintenance organization subscribers, the health maintenance organization shall have at least the equivalent of one full-time physician per 1200 members.

(4) To meet physician-subscriber ratios, a health maintenance organization may use licensed and certified physician-extenders such as nurse practitioners, nurse midwives and physician assistants.

(i) A health maintenance organization shall include in its application a summary of the qualifications and experience of each physician-extender.

(ii) For the purposes of this subsection, a physician-extender shall be counted as ½ of a physician.

(iii) There shall not, at any time, be more than two physician-extenders per primary care physician.

(5) An individual practice association health maintenance organization shall submit to the Department evidence of other standards or mechanisms which it applies to assure patient access to physicians as necessary to meet the intent of the standards in this subsection.

(6) Each physician must be licensed to practice medicine in this Commonwealth.

(7) Each physician must have staff privileges in at least one hospital utilized by the health maintenance organization within its service area.

(b) *Medical director standards.*

(1) A health maintenance organization shall identify a physician who shall serve as its medical director.

(2) The medical director shall be responsible, at least, for the following:

(i) General coordination of the medical care of the health maintenance organization on behalf of the health maintenance organization.

(ii) Appropriate professional staffing of the health maintenance organization.

(iii) Design of protocols for quality assurance.

(iv) Implementation of quality assurance programs and continuing education requirements.

(3) The time spent by the medical director in performing medical director functions shall not be counted in the physician-subscriber ratio required by subsection (a).

§ 9.77. Subscriber rights.

(a) A health maintenance organization shall develop and adhere to written procedures for informing subscribers of at least the following subscriber rights:

(1) A subscriber has the right to timely and effective redress of grievances through a system established under § 9.73 (relating to operational standards regarding subscriber grievance systems).

(2) A subscriber has the right to have health maintenance organization literature and materials for his use written in a manner which truthfully and accurately provides relevant information so that it is easily understood by a person of average intelligence.

(3) A subscriber has the right to obtain from his physician, unless it is not medically advisable, complete, current information concerning his diagnosis, treatment, and prognosis in terms that he can reasonably be expected to understand.

(4) A subscriber has the right to be given the name, professional status,

TN #92-01
Supersedes
TN #84-2

Approval Date JUL 30 1992 Effective Date

and function of any personnel providing health services to him.

(5) A subscriber has the right to give his informed consent before the start of any procedure or treatment.

(6) A subscriber has the right to be advised if a health care facility or any of the providers participating in his care propose to engage in or perform human experimentation or research affecting his care or treatment. A subscriber or legally responsible party on his behalf may, at any time, refuse to participate in or to continue in any experimentation or research program to which he has previously given informed consent.

(7) A subscriber has the right to refuse any drugs, treatment, or other procedure offered to him by the health maintenance organization or its providers to the extent permitted by law and to be informed by a physician of the medical consequences of the subscriber's refusal of any drugs, treatment, or procedure.

(8) A subscriber has the right to have all records pertaining to his medical care treated as confidential unless disclosure is necessary to interpret the application of his contract to his care or unless disclosure is otherwise provided for by law.

(9) A subscriber has the right to all information contained in his medical records unless access is specifically restricted by the attending physician for medical reasons.

(10) When emergency services are necessary, a subscriber has the right to obtain such services without unnecessary delay.

(11) A subscriber has the right to be informed of these rights listed in this subsection.

(b) A health maintenance organization shall offer to each subscriber who becomes ineligible to continue as part of a group subscriber agreement a nongroup subscription agreement offering the same level of benefits as are available to a group subscriber. A reasonable premium differential may be charged to a nongroup subscriber, in consideration of the somewhat higher administrative expenses involved in direct payment of premiums.

(c) No health maintenance organization shall expel or refuse to reenroll any member solely because of his health care needs nor refuse to enroll individual subscribers of a group on the basis of the health status or health care needs of such individuals.

Subchapter F.
CONTINUING
SUPERVISION OF
OPERATIONAL HEALTH
MAINTENANCE ORGANIZATIONS

§ 9.91. *Annual reports.*

(a) A corporation which has received a certificate of authority to operate a health maintenance organization from the Secretary and the Commissioner shall submit to the Department before March 1 of each year a detailed report of its activities during the preceding calendar year. The report shall include at least the following:

(1) A copy of the annual financial report submitted to the Commissioner.

(2) A copy of the quality assurance report submitted to the board of directors according to § 9.74(d) (relating to operational standards regarding quality assurance programs).

(3) A description of the grievance resolution system established according to § 9.73 (relating to operational standards regarding subscriber grievance systems), including a summary of total number of grievances handled, a compilation of causes underlying the grievances, and the resolution of grievances.

(4) A statement of the number of physicians leaving the health maintenance organization and the number of physicians replacing them.

(5) A summary of enrollment and disenrollment rates during the year.

(b) Federally qualified health maintenance organizations may submit copies of reports submitted to Federal authorities which contain substantially the information required by subsection (a).

§ 9.92. *Quarterly reports.*

(a) A health maintenance organization shall submit to the Department four times per year a detailed report concerning utilization of the health care services it provides.

(1) The report for the first quarter, January 1 to March 31, shall be submitted no later than May 15.

(2) The report for the second quarter, April 1 to June 30, shall be submitted no later than August 15.

(3) The report for the third quarter, July 1 to September 30, shall be submitted no later than November 15.

(4) The report for the last quarter, October 1 to December 31, shall be submitted concurrently with the annual report required in § 9.91 (relating to annual reports).

(b) Each report shall include utilization statistics on both a quarterly and year-to-date basis and shall contain the following minimum data:

(1) The hospitalization experience of the plan in terms of the number of days of inpatient hospitalization experienced per 1,000 subscribers on a quarterly, year-to-date, and annualized basis.

(2) The average number of physician visits per subscriber on a quarterly, year-to-date, and annualized basis.

(c) Federally qualified health maintenance organizations may submit copies of reports submitted to Federal authorites which contain substantially the same information required by this subsection.

§ 9.93. External quality assurance assessment.

(a) Within 1 year of receipt of its certificate of authority and every 3 years thereafter, or when the Department may direct for cause, each health maintenance organization shall have an external quality assurance assessment performed.

(b) The assessment shall study the quality of care being provided to plan subscribers and the effectiveness of the quality assurance program established according to § 9.74 (relating to operational standards regarding quality assurance systems).

(c) (1) The assessment shall be conducted by an expert experienced in health maintenance organization review activities.

(2) The expert shall be hired by the health maintenance organization and not involved in the operation or direction of the health maintenance organization nor in the delivery of health care services to its subscribers.

(3) The expert must be an individual or organization with recognized experience in the appraisal of medical practice and quality assurance, in a health maintenance organization setting.

(4) The expert shall be approved by the Department.

(5) The expert shall review, at least, a statistically significant sample of medical records.

(6) The expert shall issue a written report of his findings to the board of directors.

(d) A copy of the expert's report shall be submitted to the Department within 10 business days of its receipt by the health maintenance organization.

§ 9.94. Departmental investigation.

(a) The Department may investigate further any information contained in reports submitted according to §§ 9.91 and 9.92 (relating to annual reports and quarterly reports).

(b) Investigation may include onsite inspection of the health maintenance organization's facilities and records of the health maintenance organization.

(c) The Secretary or his agents shall have free access to all the books, records, papers, and documents that relate to the business of the health maintenance organization, other than financial business.

(d) The Department shall have access to medical records of health maintenance organization subscribers for the sole purpose of determining the quality of care rendered by the health maintenance organization.

§ 9.95. Federally qualified health maintenance organizations.

(a) In applying this chapter to Federally-qualified health maintenance organizations, the Department may take into account the fact and extent of compliance with Federal standards.

(b) Where there is a conflict or potential conflict between this chapter and Federal regulations applicable to Federally-qualified health maintenance organizations, the Department will coordinate directly with the appropriate Federal authority in order to attempt to remove or resolve the conflict.

§ 9.96. Board composition.

(a) *Establishment.* A corporation receiving a certificate of authority to establish, operate, and maintain a health maintenance organization under the act shall, within 1 year of the date of receipt of such certificate of authority, establish and maintain a board of directors, at least ⅓ of whom are subscribers of the health maintenance organization. The subscriber board membership selection process shall be structured in such manner so as to prevent undue influence in the selection process by nonsubscriber members of the board and to obtain diverse representation of broad segments of subscribers covered under health maintenance organizations contracts issued by the corporation.

(b) *Conflict of interest.*

(1) Each member of the board shall execute a conflict of interest statement.

(2) No member of the board of directors shall engage in the following forms of self-dealing:

(i) The sale, exchange or leasing of property, goods, or services between the health maintenance organization and a member, his employer, or an organization substantially controlled by him in a manner less favorable to the health maintenance organization than the manner in which such property, goods, or services is made available to the general public.

(ii) The furnishing of goods, services, or facilities by a health maintenance organization to a member unless such furnishing is made on a basis no more favorable to the member than the basis on which such goods, services, or facilities are made available to the general public or employes of the health maintenance organization.

(iii) Any transfer of the income or assets of the health maintenance organization to use by or for the benefit of a member except by purchase for fair market value. Excluded from this subparagraph are cash dividends, stock dividends, stock distribution and stock splits.

§ 9.97. Exceptions.

(a) The Department may, at its discretion, for justifiable reasons and only in cases where the health, safety, and welfare of any citizen would not be impaired, grant exceptions to and departures from this chapter when the policy objectives and intentions of this chapter are otherwise substantially met.

(b) A request for exceptions to this chapter shall be made in writing to the Department. A request, whether approved or not, will be retained on file by the Department. An approved request shall be retained on file by the corporation during the period the exception remains in effect.

(c) An exception granted under this chapter may be revoked by the Department at its discretion for good cause whenever the policy objectives and intentions for granting the exception will no longer be furthered.

(d) The Department will give written notice by certified mail, return receipt requested, revoking an exception and will state the reason for its action and a specific date upon which the exception will be terminated.

(1) The Department will provide for a reasonable time between the date of written notice or revocation and the date of termination of an exception for the health maintenance organization from compliance with the applicable regulations.

(2) Failure of the health maintenance organization to comply by the specified date may result in action to revoke the previously approved certificate of authority.

(3) The Department's denial or revocation of an exception is a final agency action and shall be appealable in accordance with 2 Pa. C. S. §§ 701 — 704 (relating to judicial review of Commonwealth agency action).

Subchapter G. PENALTY PROVISIONS (Reserved).

Subchapter H. CONTRACTS WITH PRACTITIONERS HOSPITALS, INSURANCE COMPANIES (Reserved).

[Pa. B. Doc. No. 83-1051. Filed August 5, 1983, 9:00 a.m.]

Title 49—PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

STATE REAL ESTATE COMMISSION

[49 PA. CODE CH. 35]

Rental Listing Referral Agents

Notice is hereby given that the State Real Estate Commission, under the authority contained in section 506 of The Administrative Code of 1929, the act of April 9, 1929 (P. L. 177) as amended, 71 P. S. § 186, and section 404 of the Real Estate Licensing and Registration Act, the act of February 19, 1980 (63 P. S. § 455.404) amends 49 Pa. Code Chapter 35, by adding sections 35.171 (relating to application for licensure as a rental listing referral agent), 35.172 (relating to the fees to be charged for licensure as a rental listing referral agent), 35.173 (which sets requirements for the managers of rental listing referral agencies), 35.174 (which establishes certain office requirements for rental listing referral agencies), 35.175 (which establishes the requirement for a contract between the rental listing referral agent and the prospective tenant) and 36.176 (which reiterates the function of a rental listing referral agent). These regulations are adopted in order to facilitate the application process associated with li-

CHAPTER 1229 - HEALTH MAINTENANCE ORGANIZATION SERVICES

GENERAL PROVISIONS

§ 1229.1. Policy.

The Medical Assistance Program provides payment for specific medically necessary services rendered to eligible recipients by Health Maintenance Organizations enrolled as providers under the program. Payment for services provided by Health Maintenance Organizations is subject to the provisions of this chapter, and Chapter 1101 of this title (relating to general provisions).

§ 1229.2. Definitions.

The following words and items, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

HEALTH MAINTENANCE ORGANIZATION (HMO) - A legal entity determined by the Assistant Secretary for Health, Department of Health and Human Services, to be organized and operated in the manner prescribed in section 1301(c) of the Social Security Act (42 U.S.C. § 300e(c)) and which provides, in the manner prescribed by section 1301(b) of the Social Security Act (42 U.S.C. § 300e(b)) at least the following health services to its eligible enrollees:

(i) inpatient hospital services

(ii) outpatient services

(iii) laboratory and x-ray services

(iv) family planning services and supplies

(v) physician services

(vi) home health services for individuals entitled to those services under the Medicaid State Plan.

SCOPE OF BENEFITS

§ 1229.21. Scope of benefits for the categorically needy.

Categorically needy recipients enrolled in a Health Maintenance Organization (HMO), are eligible for the full range of HMO services covered by the Department's contract with the HMO. The recipient will be informed of the services the HMO provides at the time he enrolls.

§ 1229.22. Scope of benefits for the medically needy.

Medically needy recipients enrolled in a Health Maintenance Organization (HMO), are eligible for the full range of HMO services covered by the Department's contract with the HMO. The recipient will be informed of the services the HMO provides at the time he enrolls.

Effective Date

Approval Date

TN #92-01
Supersedes
TN #84-2

HEALTH MAINTENANCE ORGANIZATIONS [NEW]

Cross References
Health insurance for newborn children, see section 771 et seq. of this title.
Insurance reimbursement for licensed certified nurse midwife services, see § 3961 et seq. of this title.
Rules and Regulations
Advertising of insurance, see 31 Pa. Code § 51.1 et seq.
Advertising practices, see 31 Pa.Code § 1...6.
Consumer affairs program, see 31 Pa. Code § 137.3.
Health maintenance organization services, see 55 Pa.Code § 1229.1 et seq.
Loss prevention activity, report, see 31 Pa.Code § 137.1.

§ 1551. Short title

This act shall be known and may be cited as the "Health Maintenance Organization Act."
1972, Dec. 29, P.L. 1701, No. 364, § 1, imd. effective. As amended 1980, Dec. 19, P.L. 1300, No. 234, § 1, effective in 60 days.

Title of Act:
An Act providing for the establishment of nonprofit corporations having the purpose of establishing, maintaining and operating a health service plan; providing for supervision and certain regulations by the Insurance Department and the Department of Health; giving the Insurance Commissioner and the Secretary of Health certain powers and duties; exempting the nonprofit corporations from certain taxes and providing penalties.
1972, Dec. 29, P.L. 1701, No. 364.

1980 Amendment: Changed name from "Voluntary Nonprofit Health Service Act of 1972".

Section 8(b) of Act 1980, Dec. 19, P.L. 1300, No. 234, provides as follows:
"(b) The commissioner and the secretary shall jointly, on the effective date of this act, issue a health maintenance organization certificate of authority to each organization previously approved as a voluntary nonprofit health service plan by the Insurance Commissioner and Secretary of Health."

Cross References
Unfair insurance practices, see §§ 1171.1 to 1171.15 of this title.

§ 1552. Purpose

The purpose of this act is to permit and encourage the formation and regulation of health maintenance organizations and to authorize the Secretary of Health to provide technical advice and assistance to corporations desiring to establish, operate and maintain a health maintenance organization to the end that increased competition and consumer choice offered by diverse health maintenance organizations can constructively serve to advance the purposes of quality assurance, cost-effectiveness and access.
1972, Dec. 29, P.L. 1701, No. 364, § 2, imd. effective. As amended 1980, Dec. 19, P.L. 1300, No. 234, § 1, effective in 60 days.

1980 Amendment: Substantially rewrote section.

§ 1553. Definitions

As used in this act:
"Basic health services" means those health services, including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, ambulatory physician care, and outpatient and preventive medical services.
"Court" means the Commonwealth Court of Pennsylvania.
"Commissioner" means the Insurance Commissioner of the Commonwealth of Pennsylvania.
"Direct provider" means an individual who is a direct provider of health care services under a benefit plan of a health maintenance organization or an individual whose primary current activity is the administration of health facilities in which such care is provided. An individual shall not be considered a direct provider of health care solely because the individual is a member of the governing body of a health-related organization.
"Health maintenance organization" means an organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled subscribers for a fixed prepaid fee.

"Secretary" means the Secretary of Health of the Commonwealth of Pennsylvania.
1972, Dec. 29, P.L. 1701, No. 364, § 3, imd. effective. As amended 1980, Dec. 19, P.L. 1300, No. 234, § 1, effective in 60 days.

1980 Amendment: Added definitions of "basic health services", "direct provider" and "health maintenance organization"; deleted definition of "medical care foundation" and made editorial changes.

§ 1554. Services which shall be provided

(a) Any law to the contrary notwithstanding, any corporation may establish, maintain and operate a health maintenance organization upon receipt of a certificate of authority to do so in accordance with this act.
(b) Such health maintenance organizations shall:
(1) Provide either directly or through arrangements with others, basic health services to individuals enrolled;
(2) Provide either directly or through arrangements with other persons, corporations, institutions, associations or entities, basic health services; and
(3) Provide physicians' services (i) directly through physicians who are employees of such organization, (ii) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis or (iii) under similar arrangements which are found by the secretary to provide adequate financial incentives for the provision of quality and cost-effective care.
1972, Dec. 29, P.L. 1701, No. 364, § 4, imd. effective. As amended 1980, Dec. 19, P.L. 1300, No. 234, § 1, effective in 60 days.

1980 Amendment: Substituted "Shall" for "May" in section head and substantially rewrote subsecs. (a) and (b).

§ 1555. Repealed. 1980, Dec. 19, P.L. 1300, No. 234, § 2, effective in 60 days

The repealed section, derived from Act 1972, Dec. 29, P.L. 1701, No. 364, § 5 and amended by Act 1978, April 28, P.L. 202, No. 53, § 2(a)[1462], related to incorporation of corporations establishing nonprofit health service plans.

§ 1555.1 Certificate of authority

(a) Every application for a certificate of authority under this act shall be made to the commissioner and secretary in writing and shall be in such form and contain such information as the regulations of the Departments of Insurance and Health may require.
(b) A certificate of authority shall be jointly issued by order of the commissioner and secretary when
(1) The secretary has found and determined that the applicant:
(i) Has demonstrated the potential ability to assure both availability and accessibility of adequate personnel and facilities in a manner enhancing availability, accessibility and continuity of services;
(ii) Has arrangements for an ongoing quality of health care assurance program; and
(iii) Has appropriate mechanisms whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis; and
(2) The commissioner has found and determined that the applicant has a reasonable plan to operate the health maintenance organization in a financially sound manner and is reasonably expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

Effective Date
Approval Date
N #92-01
upersedes
N #84-2

(ii) Arrangements for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization.

(iii) Any agreement with providers of health care services whereby they assume financial risk for the provision of services to subscribers.

(iv) Any deposit of cash, or guaranty or maintenance or minimum restricted reserves which the commissioner, by regulation, may adopt to assure that the obligations to subscribers will be performed.

(c) Within ninety days of receipt of a completed application for a certificate of authority, the commissioner and secretary shall jointly either:

(1) approve the application and issue a certificate of authority; or

(2) disapprove the application specifying in writing the reasons for such disapproval. Any disapproval of an application may be appealed in accordance with Title 2 of the Pennsylvania Consolidated Statutes (relating to administrative law and procedure).

1972, Dec. 29, P.L. 1701, No. 364, § 5.1, added 1980, Dec. 19, P.L. 1300, No. 234, § 3, effective in 60 days.

Library References
Insurance ⇨4.2.
C.J.S. Insurance § 87.

§ 1556. Repealed. 1980, Dec. 19, P.L. 1300, No. 234, § 2, effective in 60 days

The repealed section was enacted by Act 1972, Dec. 29, P.L. 1701, No. 364, § 6, and related to foreign nonprofit health service plans.

§ 1556.1 Foreign health maintenance organizations

(a) A health maintenance organization approved and regulated under the laws of another state may be authorized by issuance of a certificate of authority to operate or do business in this Commonwealth by satisfying the commissioner and the secretary that it is fully and legally organized under the laws of its state, and that it complies with all requirements for health maintenance organizations organized within the Commonwealth.

(b) The commissioner and the secretary may waive or modify the provisions of this act under which they have the authority to act if they determine that the same are not appropriate to a particular health maintenance organization of another state, that such waiver or modification will be consistent with the purposes and provisions of this act, and that it will not result in unfair discrimination in favor of the health maintenance organization of another state.

(c) The commissioner and the secretary are hereby authorized and directed to develop with other states reciprocal licensing agreements concerning the licensure of health maintenance organizations which permit the commissioner and the secretary to accept audits, inspections and reviews of agencies from other states to determine whether health maintenance organizations licensed in other states meet Commonwealth requirements.

1972, Dec. 29, P.L. 1701, No. 364, § 6.1, added 1980, Dec. 19, P.L. 1300, No. 234, § 3, effective in 60 days.

Library References
Insurance ⇨15.
C.J.S. Insurance § 75 et seq.

§ 1557. Board of directors

A corporation receiving a certificate of authority to operate a health maintenance organization under the provisions of this act shall be organized in such a manner that assures that at least one-third of the members

will be subscribers of the organization. The board of directors shall be elected in the manner stated in the corporation's charter or bylaws.

1972, Dec. 29, P.L. 1701, No. 364, § 7, imd. effective. As amended 1980, Dec. 19, P.L. 1300, No. 234, § 4, effective in 60 days.

1980 Amendment: Substantially rewrote section.

§ 1558. Contracts with practitioners, hospitals, insurance companies, etc.

(a) Contracts enabling the corporation to provide the services authorized under section 4 of this act[1] made with hospitals and practitioners of medical, dental and related services shall be filed with the secretary. The secretary shall have power to require immediate renegotiation of such contracts whenever he determines that they provide for excessive payments, or that they fail to include reasonable incentives for cost control, or that they otherwise substantially and unreasonably contribute to escalation of the costs of providing health care services to subscribers, or that they are otherwise inconsistent with the purposes of this act.

(b) A health maintenance organization may reasonably contract with any individual, partnership, association, corporation or organization for the performance on its behalf of other necessary functions including, but not limited to, marketing, enrollment, and administration, and may contract with an insurance company authorized to do an accident and health business in this State or a hospital plan corporation or a professional health service corporation for the provision of insurance or indemnity or reimbursement against the cost of health care services provided by the health maintenance organization as it deems to be necessary. Such contracts shall be filed with the commissioner.

1972, Dec. 29, P.L. 1701, No. 364, § 8, imd. effective. As amended 1980, Dec. 19, P.L. 1300, No. 234, § 4, effective in 60 days.

[1] Section 1554 of this title.

1980 Amendment: In subsec. (a), substituted "secretary" for "commissioner" and in subsec. (b), substituted "health maintenance organization" for "health service plan".

Cross References
Unfair insurance practices, see §§ 1171.1 to 1171.15 of this title.

§ 1559. Right to service or benefits when outside the state

If a subscriber entitled to services provided by the corporation necessarily incurs expenses for such services while outside the service area, the health maintenance organization to which the person is a subscriber may, in its discretion and if satisfied both as to the necessity for such services and that it was such as the subscriber would have been entitled to under similar circumstances in the service area, reimburse the subscriber or pay on his behalf all or part of the reasonable expenses incurred for such services. Such decision for reimbursement shall be subject to review by the commissioner at the request of a subscriber.

1972, Dec. 29, P.L. 1701, No. 364, § 9, imd. effective. As amended 1980, Dec. 19, P.L. 1300, No. 234, § 4, effective in 60 days.

1980 Amendment: Substituted "health maintenance organization" for "voluntary nonprofit health service corporation" following "outside the service area, the".

§ 1560. Supervision

(a) Except as otherwise provided in this act, a health maintenance organization operating under the provisions of this act shall not be subject to the laws of this State now in force relating to insurance corporations engaged in the business of insurance nor to any law hereafter enacted relating to the business of insurance unless such law specifically and in

Effective Date
Approval Date
#92-01
supersedes
#84-2

(C) The regulations of the Insurance Department, 31 Pa. Code Chapter 301, are amended by amending §§ 301.2, 301.42 and 301.61—301.63 to read as set forth in Annex A.

(D) The Insurance Commissioner shall submit this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(E) This order shall take effect upon publication in the *Pennsylvania Bulletin*.

CONSTANCE B. FOSTER,
Insurance Commissioner

Fiscal Note: 11-62. No fiscal impact; (8) recommends adoption.

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 19 Pa.B. 3916 (September 9, 1989).)

Annex A

TITLE 31. INSURANCE

PART X. HEALTH MAINTENANCE ORGANIZATIONS

CHAPTER 301. HEALTH MAINTENANCE ORGANIZATIONS

Subchapter A. GENERAL INFORMATION

§ 301.2. Definitions.

(a) No contract or evidence of coverage delivered or issued for delivery to a person by an HMO established or operating in this Commonwealth may contain definitions respecting the matters in subsections (b) and (c) unless the definitions are consistent with this section.

(b) Definitions other than those in this section may be used as appropriate if they do not contradict the definitions in this subsection. Definitions used in the contracts or evidence of coverage shall be in alphabetical order.

(c) The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act—The Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

Affiliated provider or *participating provider*—A provider that has entered into a contractual agreement either directly or indirectly with an HMO to provide health care services to members.

Certificate of authority—The document issued jointly by the Secretary and the Commissioner permitting a corporation to establish, maintain and operate a health maintenance organization.

Commissioner—The Insurance Commissioner of the Commonwealth.

Contractholder—An entity consisting of employes or members which has purchased a group contract from an HMO for the provision of specific health care services to its eligible employes or members.

Department—The Insurance Department of the Commonwealth.

Evidence of coverage—A certificate, agreement or contract issued to a subscriber setting out the coverage to which the member is entitled.

Federally qualified health maintenance organization—An entity which has been found by the Secretary of the United States Department of Health and Human Services to meet the requirements of section 1301 of the Public Health Service Act (42 U.S.C.A. § 300e).

Group contract—A contract for health care services which by its terms limits eligibility to members of a specified group.

HMO—health maintenance organization—An organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled members for a fixed prepaid fee.

Individual contract or *nongroup contract*—A contract for health care services issued to and covering an individual or family member.

Medical necessity or *medically necessary*—Appropriate and necessary services as determined by the HMO which are rendered to a member for a condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness or injury and which are not provided only as a convenience.

Member or *enrollee*—An individual who is contractually entitled to receive basic health services from an HMO.

Primary care physician—A physician who supervises, coordinates and provides initial and basic care to members; initiates their referral for specialist care and maintains continuity of patient care.

Provider—A physician, hospital or other person licensed and practicing within the scope of the license or otherwise authorized in this Commonwealth to furnish health care services.

Secretary—The Secretary of Health of the Commonwealth.

Service area—The geographical area as approved by the Commissioner within which the HMO provides or arranges for health services for members.

Subscriber—A member whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

Subchapter C. APPLICATION FOR CERTIFICATE OF AUTHORITY

§ 301.42. Content of application for certificate of authority.

An application for a certificate of authority under the act shall be made in writing in triplicate to the Commissioner. The application shall contain the following information:

(1) A copy of the basic organizational documents of the applicant organization, such as the articles of incorporation and amendments thereto.

(2) A copy of the bylaws, rules and regulations or similar documents governing the conduct of the internal affairs of the applicant corporation.

(3) A list of the names, addresses and official positions of the members of the Board of Directors of the applicant corporation and of persons who are to be responsible for the conduct of the affairs of the applicant. The list shall include the Executive Director or President, Medical Director, Director of Marketing and Director of Finance, and notarized biographical forms for each.

(4) A description of the service area of the proposed HMO, including geographic boundaries, demographic data and identification of population groups which would be sources of prepayment.

(5) Copies of the applicant corporation's proposed contracts with subscribers and groups of subscribers, includ-

ing evidence of coverage forms, setting forth the corporation's contractual obligations to provide basic health services.

(6) Copies of the applicant corporation's proposed contracts with physicians, groups of physicians organized on a group-practice or individual-practice basis, hospitals, skilled nursing facilities and other providers of health care services enabling it to provide health services to a voluntarily enrolled population.

(7) Copies of a proposed contract with an individual, partnership, association or corporation for the performance on its behalf of necessary functions, including marketing, enrollment and administration of a contract with an insurance company, hospital plan corporation or professional health service corporation for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the HMO.

(8) A detailed description of the applicant corporation's proposed grievance resolution system whereby the complaints of its members may be acted upon promptly and fairly.

(9) A copy of the applicant corporation's proposed premium rates and a detailed description of the underlying assumptions utilized in deriving rates, which shall be submitted separate from the remainder of the application for certificate of authority. The actuarial methodology used in deriving premium rates may not be considered public information. The detailed description of the underlying assumptions used in deriving rates shall include:

(i) Projected hospital and skilled nursing facility inpatient utilization in days per 1,000 members per year, subdivided by age or sex.

(ii) Projected hospital costs attributable to hospitals to be specifically utilized by the HMO through contract or otherwise.

(iii) Projected outpatient and same day hospital utilization in services per 1,000 members per year, subdivided by age or sex, as applicable.

(iv) Projected outpatient and same day hospital costs attributable to hospitals to be utilized by the HMO by contract or otherwise.

(v) Projected utilization of various physician services, such as primary office, inpatient and surgical, expressed in terms of number of visits per 1,000 members per year, subdivided by age or sex.

(vi) Projected cost of physicians' services, expressed in terms of cost per visit or per service.

(vii) Identification of physician services that are included in primary care capitation, if applicable. If there is a specialist capitation, services shall be identified.

(viii) Projected cost of emergency and out-of-area services of non-HMO providers, differentiated as to hospital and medical service components.

(ix) Projected cost and utilization of other services, such as prescription drug, home health, eye or ear exams, mental health, substance abuse and medical equipment.

(x) Identification of copays, if any, and their effect on rates.

(xi) Identification of incentive arrangements and risk pool arrangements in provider agreements, and their effect on rates. The categories of provider services covered by the arrangements shall be identified.

(xii) Identification, justification and derivation of a separate trend factor. For each separate trend factor, the specific benefits to which the trend factor applies shall be identified.

(xiii) Identification and justification of reserve or surplus contribution factors.

(xiv) Identification and justification of profit factor.

(xv) Projected cost of reinsurance.

(xvi) Projected amount of investment income.

(xvii) A detailed breakdown of administration expenses into component parts including management fees.

(xviii) Identification of demographic information used to convert the total cost per member per month to the proposed premium rates.

(xix) Identification and derivation of large group rate adjustment formulas.

(xx) A rate table listing proposed premium rates by effective period, class of membership and applicable contract form number which is separate from the rate justification materials.

(xxi) Projected financial statements, including schedules of cash flow, for a number of years that go at least past the breakeven point. Assumptions underlying the financial statements, including the projected number of members, shall be included.

(10) A map of the service area showing the locations of the providers used by the HMO.

(11) A detailed description of incentives for cost control within the structure and function of the proposed HMO.

(12) Evidence of initial capitalization in the form of a restricted $100,000 reserve. The reserve may be invested under the investment provisions for a stock life company as set forth in section 404 of The Insurance Company Law of 1921 (40 P. S. § 504). The HMO shall show evidence of the availability of working capital over $100,000.

(13) A detailed description of reinsurance contracts and a description of insolvency reinsurance obtained by the HMO.

(14) A statement that no funds may be transferred out of this Commonwealth by the HMO without the prior approval and written consent of the Department.

(15) A copy of the applicant corporation's most recent financial statement.

(16) A description of the applicant corporation's capability to collect and analyze necessary data relating to the utilization of health care services by enrolled members.

(17) A copy of the proposed general subscriber literature.

(18) A procedure for referral of members to nonparticipating specialists.

(19) Written procedures for payment of emergency services provided by other than a participating provider.

(20) A description of the manner in which members will be selected to meet the statutory requirement that 1/3 of the board members be members.

(21) A description of the system established to ensure that the records of the corporation pertaining to its

operation of an HMO are identifiable and distinct from other activities in which the corporation may engage.

(22) Other information that the applicant corporation may wish to submit which reasonably relates to its ability to operate and maintain an HMO.

(23) Other information which the Commissioner finds necessary to review an HMO's application.

Subchapter D. OPERATIONAL STANDARDS FOR A HEALTH MAINTENANCE ORGANIZATION

§ 301.61. Operational standards.

A corporation receiving a certificate of authority to establish and operate an HMO under the act shall provide quality health care services in a cost-effective manner and in a manner which does not impair the corporation's ability to deliver, arrange for the delivery of or pay for health services for its members.

§ 301.62. Subscriber contracts and evidences of coverage.

(a) *General filing procedure.*

(1) *Number of copies.* The HMO shall file group and nongroup contract forms and evidences of coverage, in duplicate. One copy will be retained by the Department, and the other copy will be returned to the HMO with the action taken by the Department noted thereon.

(2) *Time of filing.* Contract forms and evidences of coverage shall be filed with the Commissioner and deemed approved unless explicitly rejected within 60 days of the filing. Disapproval of a filing by the Commissioner may be appealed under 2 Pa.C.S. (relating to administrative law and procedure).

(3) *Form number.* A form shall be identified with a distinguishing form number on the cover of the form.

(4) *Hypothetical data.* Blank spaces in the proposed contract form and evidence of coverage shall be completed with hypothetical data demonstrating the purpose and use of the forms.

(5) *Final print required.* Contract forms and evidences of coverage shall be submitted in final print, in the form intended for actual issue, for formal filing. Initial submissions of contract forms and evidences of coverage may be in other than final print when the HMO desires a preliminary review of forms before preparing final printed documents.

(6) *Letter of submission.* The letter of submission shall be in duplicate and shall contain:

(i) The form number of each form submitted.

(ii) An explanation of the coverage provided.

(iii) An explanation of the specific purpose and use of the form.

(iv) Identification of the previously approved form which is to be replaced by the newly submitted form.

(v) Identification of forms no longer being used by the HMO.

(b) *Disclosure requirements.*

(1) Contract forms and evidences of coverage shall clearly and prominently state that coverage is limited to services provided by affiliated providers, except in emergency situations or when authorized in advance by an affiliated provider.

(2) Contract forms and evidences of coverage shall clearly explain the limitations on emergency and out-of-area services.

(3) Contract forms and evidences of coverage shall contain a complete, accurate and easily understood description of contract benefits, limitations and exclusions.

(4) Contract forms and evidences of coverage shall state that changes in premium rates and contract forms are subject to prior review and approval by the Department.

(c) *Emergency benefits and services.* The contract and evidence of coverage shall contain a specific description of benefits and services available for emergencies 24 hours a day, 7 days a week, including disclosure of restrictions on emergency benefits and services. The forms shall explain the procedures to be followed to secure medically necessary emergency health services. Emergency care service shall be covered in and out of the service area. No contract or evidence of coverage may limit the availability of emergency services within the service area only to affiliated providers. No emergency room copayment in excess of primary care copayment may be charged if the member has been referred to the emergency room by a primary care physician or the HMO and the services could have been provided in the primary care physician's office.

(d) *Copayment requirements.* Contract forms, evidences of coverage and marketing literature shall contain a complete, accurate and easily understood description of copayment requirements. Copayments shall be described in specific dollar amounts.

(e) *Arbitration.* Contract forms and evidences of coverage may not require a member to submit to binding arbitration for settlement of a dispute between the member and the HMO.

(f) *Subrogation.* If the contract contains a subrogation or reimbursement provision, the provision shall state that the right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation.

(g) *Transplant procedures.* Benefits for a covered transplant procedure shall include coverage for the medical expenses of a live donor to the extent that those medical expenses are not covered by another program.

(h) *Preexisting conditions.*

(1) No preexisting condition limitation provision may be more restrictive than the following:

(i) A preexisting condition is a disease or physical condition for which an individual received medical advice or treatment within 90 days immediately prior to becoming covered under the contract.

(ii) The condition shall be covered in full after the individual has been covered under the contract for 12 months.

(2) Group contracts shall give the member credit toward satisfaction of the preexisting condition limitation for the period of time the member was covered by the group's prior health care plan or alternate health care plan.

(3) Nongroup conversion contracts shall give the member credit toward satisfaction of the preexisting condition limitation for the period of time the member was covered by the prior group contract.

(4) If a contract includes a preexisting condition limitation, the enrollment form shall contain a question and provision for answer in the following form: "NOTICE: The following question must be answered: Do you understand that the HMO will not provide coverage during the first _____ month(s) of enrollment

for health care services required for the treatment of any disease or physical condition which required medical advice or treatment within 90 days prior to enrollment?"

(5) Contracts may not utilize individual impairment riders whereby coverage for a specific condition of a specific individual is limited or excluded.

(i) *Termination of coverage.*

(1) The contract and evidence of coverage shall clearly state the conditions upon which cancellation or termination may be effected by the HMO or the member.

(2) No HMO may cancel or terminate coverage of services provided a member under an HMO contract except for one of the following reasons:

(i) Failure to pay the amounts due under the contract.

(ii) Fraud or material misrepresentation in the use of services or facilities.

(iii) Violation of the material terms of the contract.

(iv) Failure to continue to meet the eligibility requirements under a group contract, if a conversion option is offered.

(v) Termination of the group contract under which the member was covered.

(vi) Failure of the member and the primary care physician to establish a satisfactory patient-physician relationship if:

(A) It is shown that the HMO has, in good faith, provided the member with the opportunity to select an alternative primary care physician.

(B) The member has repeatedly refused to follow the plan of treatment ordered by the physician.

(C) The member is notified in writing at least 30 days in advance that the HMO considers the patient-physician relationship to be unsatisfactory and specific changes are necessary in order to avoid termination subject to HMO grievance procedure.

(vii) Another reason approved by the Commissioner.

(3) No HMO may cancel or terminate a member's coverage for services provided under an HMO contract on the basis of the status of the member's health.

(4) No HMO may cancel or terminate a member's coverage for services provided under an HMO contract on the basis that the subscriber has exercised rights under the HMO's grievance system by registering a complaint against the HMO.

(5) No HMO may cancel or terminate a member's coverage for services provided under an HMO contract without giving the member written notice of termination including the reason for termination. Termination is not effective for at least 15 days from the date of mailing. If the notice is not mailed, effective termination is from the date of delivery. For termination due to nonpayment of premium, the grace period shall be at least 30 days.

(6) A member's misuse of a membership card will not result in termination of coverage for the member's entire family unless the member who misuses the membership card is the subscriber.

(7) A member's failure to establish and maintain an acceptable physician-patient relationship with a provider will not result in termination of coverage for the member's entire family unless the member is the subscriber.

(8) If a member is an inpatient in a hospital or skilled nursing facility on the date coverage is due to terminate, coverage shall be extended until the member is discharged from the hospital or skilled nursing facility, but may be terminated when the contractual benefit limit has been reached.

(j) *Coordination of benefits.* The contract and evidence of coverage may contain a provision for coordination of benefits that shall be consistent with that applicable to other carriers in this Commonwealth. Provisions or rules for coordination of benefits established by an HMO may not relieve an HMO of its duty to provide or arrange for a covered health care service to a member because the member is entitled to coverage under another contract, policy or plan, including coverage provided under government programs. The HMO is required to provide health care services first, and then may seek coordination of benefits.

(k) *Grace period.* The contract or evidence of coverage shall provide for a grace period of at least 30 days for the payment of premiums, except the first, during which coverage shall remain in effect. The contract holder shall remain liable for:

(1) The payment of the premium for the time coverage was in effect during the grace period.

(2) The member shall remain liable for copayments owed.

(l) *Claims.* The contract and evidence of coverage shall contain procedures for filing claims that include:

(1) A required notice to the HMO.

(2) How and when claim forms are obtained if they are required.

(3) Requirements for filing proper proofs of loss.

(4) A time limit for payment of claims.

(m) *Medical necessity administration.* Authorization by the member's primary care physician, or other physician providing service at the direction of the primary care physician, shall constitute proof of medical necessity for purposes of determining a member's potential liability.

§ 301.63. Rate approvals.

(a) Rates charged members or groups of members shall be filed with the Commissioner and be deemed approved unless explicitly rejected within 60 days of receipt of the filing by the Department. Disapproval of a rate filing by the Commissioner may be appealed under 2 Pa.C.S. (relating to administrative law and procedure).

(b) Rate filings shall describe the benefit package, identify the class of membership—for example, group, group conversion, nongroup and the like—and indicate the form number of the contract form to which the proposed premium rates will apply.

(c) Rate filings shall indicate the period during which the proposed premium rates will be effective for issues and renewals and the period for which the rates will be contractually guaranteed.

(d) Rate filings shall indicate the effective date of the last rate revision.

(e) Rate filings shall state the percentage by which the proposed rates exceed the current rates.

(f) Rate filings shall describe the procedures and identify the assumptions used to convert the total cost per member per month to the proposed premium rates. This includes the current and proposed assumptions for pre-

TN #92-01
Supersedes

Effective Date